OFFICE OF THE CHILD ADVOCATE
REPORT

ADOLESCENTS IN NEW JERSEY'S FOSTER CARE SYSTEM:
An Assessment of Case Practice and Recommendations for Reform

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Table of Contents

I. INTRODUCTION

A. Adolescents in Foster Care

Last year the Office of the Child Advocate (OCA) set out to answer a central question: Are adolescents in out-of-home placement regularly receiving the services necessary to prepare them for healthy, independent adulthoods? To find out, the OCA conducted an extensive case file audit involving the review of Division of Youth and Family Services (DYFS) records for 68 youth who were 15 years of age and in out-of-home placement on May 15, 2005. Throughout 2005, the OCA also conducted extensive interviews with key informed stakeholders, including youth, family members of placed youth, agency staff and advocates, and conducted a written survey of members of a statewide association of provider agencies that serve adolescents and runaway or homeless youth.

Despite varied racial, ethnic and socioeconomic backgrounds, teens in foster care have in common the central peril of their lives: their families are unwilling or unable to care for them safely and appropriately. In some instances, parental failure or inadequacy has led to neglect; in others it has led to acts of emotional, physical or sexual abuse. As a result, thousands of these youth enter the homes of resource families, social service programs or treatment centers. They may be separated from siblings and may begin living in different neighborhoods, cities or states.

For too many teens in care, adoption or reunification does not occur. Youth in care often lack continuity in placement, experiencing multiple settings for varied periods of time. Disruption in education, removal from social and familial networks, and the exacerbation of mental and behavioral health disorders commonly follow. After years spent in foster or group homes, treatment centers, transitional living programs and shelters, youth who are 18, 19 and 20

years old are frequently expected to make it on their own and function independently as adults. Unfortunately, outcomes for youth transitioning from foster care to independence are poor across the country.[1]

Recognizing those poor outcomes, the United States Congress passed the Foster Care Independence Act (FCIA) in 1999.[2] The FCIA created the John H. Chafee Independence Program and, among other things, amended Title IV-E of the Social Security Act to allow states to apply for funding specifically intended to create programs and services to promote self-sufficiency in youth preparing to exit foster care. Congressional hearings leading to the passage of the FCIA made resolute the fact that states were failing to properly prepare youth to live independently.[3] Despite this legislation, however, states continue to struggle to meet the needs of adolescents in foster care; New Jersey is no exception.[4]

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[1] GAO, *Foster Youth: HHS Actions Could Improve Coordination of Services and Monitoring of States' Independent Living Programs*, GAO-05-25 (2004) (hereinafter "*GAO Foster Youth*"). Of the approximately 530,000 youth in foster care, almost 40 percent are adolescents age 13 and older. *Id.* at 1. Approximately 19,000 youth "age out" of the foster care system annually without a permanent living arrangement or an adoptive family. *Id.*

[2] Foster Care Independence Act, 106 Pub. L. 169.

[3] *Id.* "Congress had received extensive information that adolescents leaving foster care have significant difficulty making a successful transition to adulthood; this information shows that children aging-out of foster care show high rates of homelessness, non-marital childbearing, poverty, and delinquent or criminal behavior; they are also frequently the target of crime and physical assaults." *Id.* at § 101(a)(4).

[4] *GAO Foster Youth*, *supra* n.1. New Jersey began receiving funds under the federal Chafee Act in 2000 and has experienced success in working with the non-profit community to establish a growing service array for youth in their later teen years. Garden State Coalition for Youth and Family Concerns, Inc., *Bridges to Independence: Improving Transitions to Adulthood for Youth Served by the New Jersey Division of Youth and Family Services* 12-14 (2001) (hereinafter "*Bridges*"). According to the New Jersey Department of Human Services (DHS), New Jersey has over the past several years invested state funds in transitional living beds, life-skills programs, after care and wrap-around services. The first local effort to collect data on services and outcomes for youth transitioning from care in New Jersey was completed and published by the Garden State Coalition for Youth and Family Concerns in 2001. That report identified six barriers to independence, including: 1) lack of housing; 2) limited educational support; 3) failed relational support; 4) limited medical and mental health services; 5) limited employment services and opportunities; and 6) systemic barriers. *Bridges*, 37. Significant policy advancements have been made with respect to some of these barriers, such as the implementation of the Medicaid Youth Extension Program, Statewide Tuition Waiver Program, and most recently, the policy change to continue services through the age of 21. James E. McGreevey, et al., *A New Beginning: The Future of Child Welfare in New Jersey* 92 (2004) (hereinafter "*A New Beginning*").

On any given day, there are approximately 4,000 youth between the ages of 13 and 21 in out-of-home placement in the custody of DYFS.[5] On April 27, 2005, DYFS reported there were 428 youth in out-of-home placement with the case goal of independent living in New Jersey.[6] Twenty-two percent of youth with a goal of independent living were served by DYFS' Essex County offices.[7]

B. The Office of the Child Advocate's Review

This review by the OCA assesses the quality of the State's efforts to support teenagers in foster care and prepare them for the challenges and opportunities of life beyond DYFS. Created by statute in September 2003, the OCA is a child protective agency with the authority to investigate any State agency's response to an allegation of child abuse or neglect and to review and make recommendations concerning the procedures established by any such agency that provides child protective or permanency services.[8]

To evaluate DYFS services to teenagers in foster care, the OCA randomly selected a statistically relevant sample of all 15-year-old youth who were in out-of-home placement through DYFS as of May 15, 2005, and obtained their complete DYFS case files. The file review focused only on information maintained by DYFS case managers within these files, and did not include other sources of data, such as records maintained by other divisions within state

[5] *A New Beginning*, 89.
[6] Department of Human Services, Division of Youth and Family Services, *Children in DYFS Custody Whose Case Goal is Independent Living on April 27, 2005* (on file with OCA).
[7] *Id.;* The proportion of youth in out-of-home placement in Essex County whose case goal is independent living warrants further investigation. Essex County-based youth advocates and representatives of Court Appointed Special Advocates (CASA) raised this to the OCA as a significant concern. Given the unique resources and services required to plan and support the goal of successful independent living, a closer look at models of planning and service provision may be warranted. One current proposal to address these concerns has been raised to DHS by the Nicholson Foundation, a family foundation whose philanthropic activities focus on Essex County, which is proposing to pilot an Essex County-based multi-system transition planning process for all youth transitioning from foster care or the juvenile justice system, providing for a one-stop integration of social services across life domains (employment, health, mental health, housing, education etc.).
[8] *N.J.S.A.* 52:17D-1 to–11.

government, provider agency files or schools' files. The DYFS caseworker is expected to play the central and leading role in the management of all aspects of an adolescent's case.[9] In New Jersey's present child welfare system, the case manager is charged with being the primary advocate for youth in out-of-home placement. To be effective, the case manager must know the youth's needs and how they are being addressed. Because the DYFS case manager plays this pivotal role, the OCA's review focused on the data recorded by the DYFS case manager in the complete DYFS file.

The OCA chose to evaluate services to 15-year-old youth in placement because DYFS policy requires specific planning and services to begin upon the 15th birthday of youth in care or within six months of entering care for youth who enter at age 15 or older. Neither budget nor efficacy reviews of these services are included in this report. Rather, the OCA's review was designed to measure the quality of DYFS' work with teenagers in out-of-home placement and gauge the impact of child welfare reform efforts in the lives of these young people.

C. Summary of Major Findings and Recommendations

In general, there have been significant policy and program innovations within the last two years. That said, this audit indicates that some adolescent case practices – though none which affect the safety of youth - and service provision generally for 15-year-old youth in placement require improvement. The good news is that DHS' innovations, which include a critically important expansion in transitional housing for adolescents in foster care and a new policy granting youth the option to continue placement and services through age 21, will place New

[9] Judith Reifsteck, *Failure and Success in Foster Care Programs*, 7 *North American Journal of Psychology* 2, 313-28 (2005). The study noted that youth benefit from multiple modalities of service and that individualized case management is believed to be the most effective method of coordinating multiple services, as wrapping services around a child correlates with higher outcomes for that child. *Id.*

Jersey at the forefront of efforts nationally to care for adolescents in foster care when fully and consistently implemented. In the last two years alone, the New Jersey Department of Human Services (DHS) has increased the budget for aging-out youth by $6.7 million dollars. In April 2005, transitional living and supportive housing options were expanded by 43 beds statewide with $1.7 million of these funds. DHS advises that additional contracts were recently awarded to create an additional 80 transitional beds for aging-out youth, including youth with special needs.[10]

At the same time, agency policies that required transition planning and life skills instruction for all youth in out-of-home placement at age 15 were largely respected in the breach; neither appeared to occur routinely with youth in this sample. This report is intended to afford an opportunity for public discussion on the need to redouble efforts to better support adolescents in care, to commence services and planning early, and to create for them an enduring bridge from foster care to independence. The findings contained in this report drawn from this sample of youth offer a baseline of agency performance against which future progress in the State's efforts to care for teenagers in its care can be measured.

The Office of the Child Advocate's major findings are:

(1) Transitional Plans for Adult Independence (TPAI) were not regularly developed and implemented, diverging from DYFS policy and regulatory requirements.

Despite agency policy and administrative code provisions requiring a written plan for self-sufficient living to be developed and implemented for youth in placement no later than age 15, or within six months of a child entering care who is 15 years or older, the review found no evidence that such planning routinely occurred. The OCA did not find a single meaningful TPAI

[10] Department of Human Services, *Human Services Announces $1.7 million housing expansion for aging out youth*, (April 12, 2005), *at* www.state.nj.us/humanservices/Press-2005/housing_expand.htm (visited January 3, 2006).

in any of the 68 case files reviewed. In fact, only nine percent of audited cases included any documented evidence of transition planning at all, and only six percent of cases contained some record of a conference that included reference to transition issues.

(2) Life skills instruction did not routinely occur for youth at age 15 as required by DYFS policy, and access to these services was disparate between youth in congregate care and youth in family settings.

Despite DYFS policy requiring, and nationally-recognized best practice models promoting, early and sustained life skills instruction for youth in out-of-home placement, DYFS did not routinely conduct strengths and needs assessments[11] nor provide life skills instruction to 15-year-old youth in out-of-home placement. Only 31 percent of youth in this sample received life skills instruction. Of those youth, 58 percent were residing in congregate care and 38 percent were residing in relative or resource family placement settings.

(3) Access to mental health services in this sample appears disparate with respect to race/ethnicity and requires further study.

Data within this review, which should be tested against a larger follow-up sample of youth in out-of-home placement, suggests that African-American adolescents in this sample were significantly less likely to receive mental health services as their white counterparts. No such disparity was identified with respect to Hispanic children in this sample. This report does not conclude that the disparity which appears in this sample exists statewide with respect to all children in out-of-home placement. To know that, a larger sample of children from varied locations and of all ages, will need to be analyzed.

[11] DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 1010 requires this and states that TPAI shall be based upon an assessment of using New Jersey DYFS SDM Child Strengths and Needs Assessment (DYFS form 22-25), and DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 1010.2 which indicates that resource parents or a caring adult should utilize the "On the Road Toward Independence" to guide the youth in a self assessment of developing life skills.

(4) Evidence of trauma in the lives of the youth in this sample is high, as expected, yet the rate of diagnosis of Post Traumatic Stress Disorder (PTSD) is relatively low.

Witnessing or suffering a violent event figured prominently in the lives of the youth within this sample. Sixty-eight percent of the teens in this review endured or witnessed a traumatic episode of violence, but only 19 percent of the youth in this sample were noted to have experienced post-traumatic stress. This data raises the possibility that PTSD may be under-diagnosed among adolescents in out of home placement, and bears further scrutiny through a larger sample review. Traumatic history and the trauma of a youth's removal from home should not go unrecognized in routine case practice. Early intervention and, if appropriate, diagnosis and treatment are critical.

(5) Regular and direct contact between case managers and youth in care is inadequate and files lack current and complete documentation of critical needs.

Case files revealed that DYFS case manager visitation requirement (MVR) schedules with youth were frequently not satisfied; medical, mental health and education records were outdated or incomplete; and little information was available with regard to a youth's current progress toward case goals. Of all the cases in which there were MVR schedules, DYFS was out of compliance 57 percent of the time, and 29 percent of cases demonstrated no recorded discussion of case goals during any MVR visits.

(6) Child Welfare Reform Plan

The Child Welfare Reform Plan makes a number of bold commitments to improve services for adolescents in care. Independent living options for youth transitioning from foster care have been significantly increased in the last year. Chief among the balance of commitments is the promise to improve case practice, planning and resource linkages for teens in care. The

OCA's findings, which suggest real deficiencies in adolescent case practice, at least through May 15, 2005, underscore the critical need for successful implementation of the plan's commitments.

As a result, the OCA's major recommendations are:

- Consistent and meaningful MVRs and concurrent permanency planning are two elements of case practice that need heightened measures of supervisory oversight and management accountability;

- In order to strengthen the role of resource parents in assuring youth have access to life skills training and informal training at home, the agency would do well to continue to develop strategies for stabilizing youth in their placements, providing greater likelihood that meaningful relationships will develop between youth and their caregivers;

- All youth 15 years and older in out-of-home placement should undergo a child strength and needs assessment and have the opportunity to complete the self assessment of strengths and needs from the "On the Road Toward Independence" administered by their case managers annually;

- Youth entering out-of-home placement should receive a mental health assessment and, where appropriate, receive mental health counseling and support services; promote equity and efficacy in the provision of mental health services to children in out-of-home placement by advancing national evidence-based models of intervention with children and families;

- Life skills instruction should be made a significant component of every adolescent's experience in out-of-home placement;

- Formal transition planning conferences should begin in compliance with DYFS policy and the administrative code.

II. FINDINGS

A. Description of Youth Demographics

This section provides descriptive information about the youth reviewed in this study, including: gender, race/ethnicity, citizenship and primary language. Table 1.1 shows the number and percentages by gender of youth within this sample. As indicated, males appeared in the review at a rate over twice that of females. While this is unrepresentative of the gender distribution among children in placement generally, it does not mark a significant deviation from the gender distribution for adolescents in placement specifically. The distribution in Table 1.2 represents the distribution of youth within this sample by race/ethnicity.

Table 1: **Demographic Information (N = 68)**

Table 1.1: Gender

Gender	frequency	%
Male	47	69.1
Female	21	30.9

Table 1.2: Race/Ethnicity

Race/Ethnicity	frequency	%
African-American	35	51.5
White	19	27.9
Hispanic/Latino	10	14.7
Asian/Pacific Islander	2	2.9
Interracial	1	1.5
Unknown	1	1.5

As evidenced by Tables 1.3-1.4 that follow, nearly two-thirds of youth in this sample were either born in the United States or affirmatively identified as United States citizens. Similarly, English was the primary language for nearly 90 percent of youth in the sample. More than a quarter of youth, however, had unknown nationalities or were born outside of the United States. The percentage of children born outside of the United States within this sample is not surprising, given the richness of New Jersey's diversity, but the lack of information in case files with regard to national origin and citizenship is of concern. Significant immigration issues may arise for youth in care who do not possess legal status upon reaching the age of majority if appropriate actions are not taken by the State to ensure citizenship.[12]

Table 1.3

Citizenship	frequency	%
US Citizen	50	73.5
Unknown	18	26.5

Table 1.4

First Language	frequency	%
English	61	89.7
Spanish	7	10.3

B. Data on Placement and Permanency Planning

This section provides descriptive information about the average amount of time the youth in this sample spent in out-of-home placement, their geographic location, permanency goal,

[12] A youth who has been declared dependant by a juvenile court or is in the custody of a state agency for long-term foster care because of abuse, neglect, or abandonment is eligible under federal immigration law for a "Special Immigrant Juvenile" visa. 8 *U.S.C.* § 1101(a)(27)(J)(i). Obtaining such a visa allows the child to apply for permanent resident status. *M.B. v. Quarantillo*, 301 F.3d 109, 114 (3d Cir. 2002).

current placement type, number of placements experienced since entering care, and the number of assigned case managers throughout the youth's involvement with DYFS.

Consistent with national statistics, a large percentage of the youth in this sample have been involved with the foster care system for multiple years – many since they were very young.[13] On average, as of May 15, 2005, the youth in this sample spent an average of 3.5 years in out-of-home placement, in an average of four different placements, and had four different case managers during their time in care. Thirty-three percent of youth had four or more case managers. Thirty-two percent of the youth in this sample had four or more placements, including one youth who had 25 separate placements.

Forty-seven percent of youth had permanency goals that included reunification. In an effort to reduce a child's length of time in out-of-home placement without permanency, New Jersey's Child Welfare Reform Plan commits to concurrent planning – the practice of vigorously pursuing family reunification while simultaneously developing plans for an alternative permanent family – at the moment of a youth's removal from home.[14] Within this sample, only 20 percent of cases reflected efforts of concurrent planning, which is encouraged by federal law and authorized by State law.[15] Most critically, there was no documented evidence of a permanency goal for nine percent of the youth in this sample. Failure to document goals and exercise "reasonable efforts" in pursuing permanency with respect to any placement type may yield adverse consequences to both the youth and the State.

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[13] Casey Family Programs, *Improving Foster Care: Findings from the Northwest Foster Care Alumni Study* (rev. 2005) 23. The OCA sample concurs with this finding (66 percent of the sample were 12 years old at their first removal from home and 12 percent were five years old or younger at first removal.)

[14] *A New Beginning*, 49.

[15] 42 *U.S.C.* § 673b(i)(2)(B) (authorizing the federal government to provide technical assistance regarding models of concurrent planning) to incentive-eligible states); 45 *C.F.R.* 1356.21(b)(4) (authorizing concurrent planning); *N.J.S.A.* 9:6-8.8(b)(3) (same); *N.J.S.A.* 30:4C-11.1(c) (same).

Table 2: Current Permanency Goal: By Category (N = 68)

Planning Type & Goal(s)	frequency	%
Concurrent Planning Goals	**14**	**20.6**
Reunification & Kinship Legal Guardianship (1)*	*7*	*10.3*
Reunification & Independent Living (1)	*1*	*1.5*
Reunification & Institutional Care/Treatment (1)	*1*	*1.5*
Reunification & Other (residential placement) (1)	*1*	*1.5*
Independent Living & Other adoption (2)	*1*	*1.5*
Independent Living & Other (missing) (2)	*1*	*1.5*
Long-term Foster Care & Other (unspecified) (2)	*1*	*1.5*
Kinship Legal Guardianship & Independent Living (2)	*1*	*1.5*
Non-concurrent Planning Goals	**53**	**77.9**
Reunification (1)	*19*	*27.9*
Long-term Foster Care (2)	*10*	*14.7*
Unknown (4)	*6*	*8.8*
Foster Home Adoption (2)	*5*	*7.4*
Independent Living (2)	*4*	*5.9*
Kinship Legal Guardianship (2)	*4*	*5.9*
Other (long-term specialized care) (2)	*3*	*4.4*
Institutional Care/Treatment (2)	*1*	*1.5*
Other Adoption (2)	*1*	*1.5*
N/A – reunified with family (3)	**1**	**1.5**

*Note: parenthetical numeral indicates aggregate group membership 1 = reunification goal, 2 = non-reunification goal, 3 = n/a – reunified with family, and 4 = unknown

A positive finding in case management was that most youth in the sample were apparently at an appropriate grade level. Fifteen-year-old youth generally should be enrolled in the 9th or 10th grades. Based on this record review,[16] the majority of youth in the sample (90 percent) had completed the 8th grade. Within the sample, 56 percent had a history of being classified at some point in their education and 40 percent were currently classified. Despite the fact that classified youth should possess a current Individualized Education Plan (IEP), only 21 percent of the files contained such plans. Of the files, 63 percent contained a school record outlining academic standing or grades.

[16] The OCA audit found a record of the last completed school grade in 97 percent of the files.

C. Transitional Plans for Adult Independence (TPAI)

The DYFS Policy Manual, in a section entitled "Self-sufficiency of Adolescents," requires the completion of a TPAI for all youth in foster care/relative care, long term foster care with or without custody, residential placement, and Independent Living.[17] The purpose of the TPAI is to develop and document a specific plan for the youth to obtain the skills and knowledge necessary to function independently as an adult.[18] The DYFS case manager must develop the TPAI with the input and participation of resource parents, the foster youth, birth parents, and other significant adults in the youth's life. The TPAI must be "based upon an assessment of the foster child's strengths, resources, interests and needs"[19] and "tailored to meet the adolescent's individual needs."[20] Participants in the planning process should consider:

- The age and maturity of the adolescent;
- Any existing disabilities;
- The length of time the youth has been in out-of-home placement;
- The number of placements;
- The level of academic functioning;
- The adolescent's emotional stability;
- The adolescent's level of self-esteem;
- The amount of familial contact and other adult resources;
- The degree of commitment from the current caregiver;
- The degree to which the adolescent has received job skill preparation;
- The adolescent's perception of the future, including his expression of job or career interests;
- The adolescent's willingness to cooperate toward the achievement of self-sufficiency;
- The specific skills needed for self-sufficiency;
- The strengths and needs of the adolescent; and
- The available community services and resources.[21]

[17] DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 1010.
[18] *Id.*
[19] *Id.*
[20] DYFS Field Operations Casework Policy and Procedures Manual II.D. Section 1010.1.
[21] DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 1010.

DYFS policy also requires that case managers complete the TPAI: (1) "during the placement review, which falls before the youth's 16th birthday;" (2) "within six months of the date of placement of those entering foster home and other out-of-home placement at the age of 15 or older;" or (3) "no later than age 15 for those already in foster home or other out-of-home placement."[22] The case manager must document the TPAI in DYFS Form 5-43, although it is also permissible for a case manager to develop the TPAI during the Regional Placement Review conferences and document the results on DYFS Form 26-81, Out-of-Home Permanency Assessment/Case Plan/Court Report.

In order to determine comprehensively whether DYFS engaged in transition planning for the youth in the sample, the OCA reviewed each file to determine whether there was a TPAI that complied with DYFS policy, memorialized on DYFS Form 5-43, DYFS Form 26-81, or in the file's contact sheets. The OCA did not find a single meaningful TPAI in any of the 68 case files reviewed. In fact, only nine percent of audited cases included any documented evidence of transition planning at all, and only six percent of cases contained some record of a conference that included reference to transition issues. There were no files containing DYFS Form 5-43. Case files did contain multiple copies of DYFS Form 26-81, which case managers complete during regional placement review conferences, but none of those forms contained anything even remotely resembling the comprehensive transition plan required by DYFS policy. The case notes also demonstrated little evidence of any transition planning.[23] Overall, the OCA's review suggests a wide berth between policy and practice.

[22] *Id.*

[23] The OCA audit contained these comments, taken from case plans completed on or about the youth's 15th birthday, which were representative of limited notes in case plans: "youth is regularly attending school and doing well" and "youth is in good health."

Life skills instruction was not routinely occurring, as required by DYFS Policy, and access to these services was disparate between youth in congregate care and youth in family settings. DYFS policy, in a section entitled "Life Skills Necessary for Adult Independence," defines the types of life skills that are critical for a successful transition from out-of-home placement to adulthood.[24] Two basic categories of life skills are listed: resource skills and functional skills. Resource skills are identified as "those concrete skills which the adolescent learns through formal or informal instruction."[25] According to DYFS policy, "[m]any resource skills are acquired through observing and participating in specific tasks related to the respective skill,"[26] such as "shopping for food and cooking a meal, establishing a savings account or opening a checking account and paying a bill."[27] Functional skills, which are "intangible and less easy to teach," include, for example, planning and problem solving.[28] The Manual of Policy and Procedures states that these skills are necessary to successfully complete resource tangible skills, and cites the example of cooking a meal to explicate the relationship. As the nature of those skills demonstrates, providing instruction to a youth at this age is critical to a child's successful and productive life after foster care.

Only 31 percent of youth in this sample received life skills instruction. Of those youth, 58 percent were residing in congregate care and 38 percent were residing in relative or resource family placement settings. At the present time, DYFS contracts with at least one private

[24] DYFS Field Operations Casework Policy and Procedures Manual II.D., Section 1010.2.
[25] DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 1010. The complete list of Resource/Tangible Skills provided in the Manual includes: educational, vocational, job search money management, home management, locating community resources, use of public transportation, health care and personal hygiene, locating housing, understanding the law and legal services, social skills, and preparing for transition to independence and termination from substitute care. *Id.* at 1010.2
[26] DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 1010.
[27] DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 1010.2.
[28] Functional/intangible skills include: decision making, problem solving, job readiness, planning, communication, interpersonal relationships, self-esteem, good citizenship, confronting past losses, rejections and disappointment, appropriate behavior, and time management. *Id.*

provider in every county of New Jersey to provide "independent living skills programs," essential life skills instruction for adolescents in out-of-home placement. This sample did not provide evidence of regular referral of youth in resource family settings to independent living programs for life skills instruction. There was also no record of resource parents being asked to lead life skills instruction. Although the adolescent is supposed to be given the opportunity to read and complete a workbook entitled "On the Road to Independence," and the accompanying form DYFS 5-42, in order to self-identify strengths, resources, interests, needs and a plan for future self-sufficiency, there was no evidence of caseworkers administering a youth self-assessment process.[29] Further, there was no record of the mandated follow-up and management of the youth's transition plan by the case manager in MVR notes, which is where one would expect to note the gap in life skills provision.[30]

D. Access to Mental Health Services

Access to mental health services for this sample of youth appeared disparate with respect to race/ethnicity. African-American adolescents, whose case files noted a concern regarding mental health status, were less likely to receive mental health services than white adolescents in the sample whose files also reflected a mental health concern. At the same time, however, access and treatment for Hispanic youth did not present with a similar disparity. As Table 3 indicates, of the African-American youth in the sample with identified mental health concerns, 52 percent appeared not to receive any mental health services. However, white youth who were identified with a mental health concern received mental health services 78 percent of the time.[31]

[29] DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 1010.1.
[30] DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 1010.4.
[31] Upon further analysis of variance the difference in current treatment rates for all youth with a record of mental/behavioral health concerns in the sample was found to be significant ($p< 0.5$, $F=2.4$, $df=5$).

This report does not conclude that the disparity which appears in this sample exists statewide with respect to all children in out-of-home placement. To know that, a larger sample of children from varied locations and of all ages, will need to be analyzed. The cause for the apparent disparity in this sample is unknown and requires investigation in New Jersey through a larger sampling of children in out-of-home placement and a causative inquiry.

Table 3: Variation in Mental/Behavioral Health Treatment by Race/Ethnicity (N = 68)

		Current Treatment		**Row Total**
Race/Ethnicity	Record of Issues	yes (%)	no (%)	(n)
White	yes	14 (77.8)	4 (22.2)	**18**
	no	0	1	**1**
	column total	**14**	**5**	**19**
African-American	yes	12 (48.0)	13 (52.0)	**25**
	no	1	9	**10**
	column total	**13**	**22**	**35**
Hispanic	yes	9 (90.0)	1 (10.0)	**10**
	no	0	0	**0**
	column total	**9**	**1**	**10**
Asian	yes	2 (100)	0	**2**
	no	0	0	**0**
	column total	**2**	**0**	**2**
Interracial	yes	1 (100)	0	1
	no	0	0	0
	column total	**1**	**0**	**1**
Unknown	yes	0	1 (100)	**1**
	no	0	0	**0**
	column total	**0**	**1**	**1**

E. Evidence of Trauma/Diagnosis of Post-Traumatic Stress Disorder (PTSD)

Witnessing or suffering a violent event figured prominently in the lives of the youth within this sample. Sixty-eight percent of the teens in this review endured or witnessed a traumatic episode of violence, but only 19 percent of the youth in this sample were noted to have experienced post-traumatic stress. It is possible that PTSD is under-diagnosed in the population. Children in out-of-home placement across the country are, in many instances, dually traumatized. The first type of trauma often comes by the acts or omissions of a parent, relative or guardian whom the child knows as his or her caregiver; the second type comes by the act of removal and separation from the familiar. Failure to adequately recognize and address these experiences in a systematic and ongoing fashion with all youth upon removal to substitute care sets the stage for future instability.[32] Unless addressed through early assessment and, where appropriate, counseling, youth who have been victimized and/or removed from the home are left ever more vulnerable to ponder, sometimes without resolution, life-altering questions about how they first came to be in foster care and why. Once in foster care, the probability of continued and new trauma is high.[33] With every change in placement or reassignment of case managers, feelings of loss and separation may occur.[34] The transition from foster care to independence is no exception.

The following excerpt was taken from a mental health clinician's progress report to a DYFS caseworker discovered in the course of this case file audit. The youth was a survivor of sexual abuse with a subsequent history of inappropriate sexually acting-out behavior. She first

[32] *See* Alvin A. Rosenfeld, et al., *Foster Care: An Update*, 4 *Journal of the American Academy of Child and Adolescent Psychiatry* 36, 448-58 (1997).
[33] *Id.*
[34] *Id.*

began receiving mental health treatment in December 2004, after eight years in mostly non-congregate care.

> Therapist was attempting to encourage the guardian to hang in with the patient and not bring another rejection into the patient's life. The heart of the matter appears to be the damage that had already been sustained by the patient in her life journey. It appears that the patient was unable to move beyond the limits of that injury and the resources of the guardian were not high enough to sustain her while the patient struggled. Both parties appear to have made a noble attempt but tragically it had not been enough.

F. Case Manager Visitation with Youth and Documentation

In order to gauge the level of DYFS case manager involvement, the OCA measured three factors: (1) contact between case managers and youth; (2) the frequency with which case plans were discussed with the youth; and (3) evidence of case manager including the youth in case planning; each of these will be discussed in turn.

With respect to case manager/youth contact, questions were constructed to determine whether there was an MVR schedule dictating the frequency with which the caseworker was required to visit the youth in placement, what that schedule was, and whether DYFS complied with that schedule. The OCA's review demonstrated that 90 percent of all case files contained identifiable MVR schedules, most often documented on a DYFS Form 26-81. Of the case files including MVR schedules, 60 percent required MVRs to occur monthly, 25 percent required placement visitation to occur quarterly, six percent required visitation to occur more than once a month, and one percent of cases required annual visitation. Of all the cases in which there were MVR schedules, DYFS was out of compliance 57 percent of the time.

The OCA also reviewed case notes and contact sheets containing records of MVRs to determine whether they reflected that the case manager was discussing the case goal with the

youth during those routine visits. The reviewer was asked to classify how often the case manager discussed the case goal with the youth, and was offered four choices: (1) "most of the time;" (2) "some of the time;" (3) "rarely;" or (4) "never." Twenty-two percent of cases contained evidence of the case manager discussing the youth's goal most of the time. Readers indicated that in 28 percent of cases, there was discussion some of the time and in 16 percent of cases, discussion of case goals occurred rarely. In 29 percent of the cases, there was no recorded discussion of case goals during any MVR visits.

Readers were also asked to identify evidence that the youth had been actively participating in the formation of the case plan. In answering this question, readers were instructed to answer affirmatively if there was any recorded instance in case notes or case plans where the youth was specifically asked for his or her opinion or had expressed a preference regarding a significant decision. A single instance of either would result in an affirmative response. Only 18 percent of cases included at least one such instance.

G. Child Welfare Reform Plan Commitments

The contention that adolescents in foster care have long been overlooked and underserved, both nationwide and in New Jersey's child welfare system, is not contested.[35] Indeed, the State acknowledged shortcomings and made bold new commitments to better serve adolescents in its multi-year Child Welfare Reform Plan. Specifically, the Child Welfare Reform Plan makes "two core commitments:" (1) to "attend to the safety, permanency, and well being of adolescents no less than those of younger children;" and (2) to "prepare adolescents to

[35] *A New Beginning*, 89 (acknowledging that historically the child welfare system has "essentially giv[en] up on [adolescents] and consign[ed] them to a 'permanency' goal of 'long term foster care.'").

live as healthy, productive adults with strong relationships with other supportive adults."[36] To implement these commitments, the Department of Human Services (DHS) committed to two "overarching" strategies. The first was to create an adolescent specialist position and ensure the placement of these specialized workers in every office.[37] Adolescent specialists were described as highly trained individuals with expert knowledge of available resources, with a particular desire and interest to work with teens in care.[38] The second was to train all workers on the principles and practices of youth development and other well-known best practices in adolescent case practice.[39]

DHS also pledged specific actions to ensure adolescent safety, permanency, and well-being, and to prepare adolescents to live as healthy, productive adults with strong relationships with other supportive adults. DHS committed to end the long-standing practice of closing youths' cases automatically upon their 18th birthdays and eliminate the use of long term foster care as a permanency goal for adolescents.[40] DHS also made the historic and commendable

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[36] *A. New Beginning*, 89.
[37] *Id.* at 90.
[38] *Id.*
[39] The New Jersey Child Welfare Reform Plan committed to "train all casework employees on the principles of practices of youth development," which would include training employees to: "build trusting relationships with adolescents of all backgrounds and cultures; work with adolescents to identify and build upon their strengths and interests; give adolescents real input in setting their goals (for permanency and for their future generally); know and be sensitive to adolescents' various developmental stages, so service and care plans are appropriate; understand that being tough and vulnerable are not mutually exclusive, and that many adolescents are both; give adolescents a voice in the selection of where they will live; and work with adolescents to help them better to formulate and articulate their own goals and desires – to help them to take up both their authority and responsibility for their own lives." *A New Beginning*, 90. The Child Welfare Reform Plan's commitment is consistent with best practices. *See, e.g.*, The Center for the Advancement of Youth, Family & Community Services, Inc., *Developing Competent Youth*, *at* http://www.rope.org/youth/ (approved by the executives of National Collaboration for Youth Members, March 1998) (defining "Youth development" as "[a] process which prepares young people to meet the challenges of adolescence and adulthood through a coordinated, progressive series of activities and experiences which help them to become socially, morally, emotionally, physically, and cognitively competent. Positive youth development addresses the broader developmental needs of youth, in contrast to deficit-based models, which focus solely on youth problems."); Carnegie Council on Adolescent Development, *A Matter of Time* (1992) ("Youth Development is the process through which adolescents actively seek, and are assisted, to meet their basic needs and build their individual assets or competencies.").
[40] *A New Beginning*, 89-97; *see also* DYFS Field Operations Casework Policy and Procedures Manual II.D, Section 601.

promise to aggressively pursue permanent homes for adolescents through age 16 and beyond, consistent with the expressed interest of the youth.[41]

The most recent monitoring report by the New Jersey Child Welfare Panel[42] identified select areas of policy improvement. The OCA concurs that very important policy changes have been made by DYFS. Providing youth the option to continue placement and services through age 21 is a remarkable reform that, if consistently and fully implemented, can protect the best interests of transitioning youth. Such implementation will place New Jersey at the forefront of efforts nationally to care for adolescents in foster care. DHS has also, to its great credit, implemented a new policy directing case managers to meet with youth six months prior to their 18th birthdays and discuss the full range of placement options and services available.[43] And, again to its great credit, DHS completed a review of all youth's cases in which long-term foster care was the permanency goal and, in 47 percent of these cases, established a new goal.[44] These are all very significant developments for adolescents in care.

The New Jersey Child Welfare Panel has supported a DHS decision to eliminate the adolescent specialist position providing the following rationale: (1) financial resources would be better spent hiring caseload-carrying front line case managers in order to further reduce worker caseloads overall; and (2) despite an overall commitment to move New Jersey's child protection system to a model of "one worker-one family,"[45] children and families may still have multiple

[41] *A New Beginning*, 93-97.
[42] On June 23, 2003, the State entered into a Settlement Agreement in *Charlie and Nadine H. v. McGreevey*, et al., Civ. Action No. 99-3678 (SRC). The Settlement Agreement created the New Jersey Child Welfare Panel. The Panel is composed of experts in child welfare and related fields. *Id.* at Section II.
[43] New Jersey Child Welfare Panel, *Period II Monitoring Report, January 1, 2005 to June 30, 2005* 53-55 (2005). Although the implementation of that policy initially suffered from confusion in the field, DHS has clarified the directive and revised the materials that explain the policy to youth as a result of concerns raised by OCA and the New Jersey Child Welfare Panel. *See also* DYFS Field Operations Casework Policy and Procedures Manual II-B, Section 403.3.
[44] *Id.*
[45] *A New Beginning*, 50, 59-62.

case managers from various systems simultaneously and the presence of any additional workers is suboptimal.[46] In light of this change to the Child Welfare Reform Plan's commitments, it is ever more important that case managers have the training, supervision, and resources available to serve the particular needs of adolescents.

III. BEST PRACTICE / LITERATURE REVIEW

A. Mental Health Support Services

Mental health problems are more prevalent among youth in foster care than their same-aged peers in the general population.[47] A recent study found foster care alumni to suffer from post-traumatic stress disorder (PTSD) at twice the rate of veterans of the war in Iraq.[48] Because foster youth may be at elevated risk of PTSD, major depression, and substance abuse disorders, the stress associated with making the transition from foster care to independent living may leave youth especially vulnerable.[49] In one study, one-third of the foster care alumni who responded suffered from one or more mental or behavioral health disorders.[50] In the year before their interview, over one-third of the participants received some kind of counseling, nearly one-quarter used prescribed drugs for a psychological or psychiatric condition, and seven percent had spent at least one night in a psychiatric hospital.[51] It is interesting to note that the same study contained another mental health indicator demonstrating resiliency in young adults despite their

[46] Theoretically, at present, a youth could have a probation officer, a DYFS case manager, a CMO or youth case manager, and case manager from a residential placement all working on her case at the same time.
[47] Casey Family Programs, *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study* 32 (rev. 2005).
[48] *Id.*
[49] Chapin Hall Center for Children at the University of Chicago, *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19*, 41 (2005)
[50] *Id.*
[51] Chapin Hall Center for Children at the University of Chicago, *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19*, (Study 1) 32-33 (2004)

life experiences. Approximately 90 percent of the sample reported they were "fairly" or "very" optimistic about the future.[52]

A recently released report by the OCA included findings of an audit of a statistically significant sample of the health records of children in placement who had received a comprehensive medical exam earlier in 2005. Utilizing Medicaid encounter data and DYFS records, the OCA found that 61 percent of the children in this sample were diagnosed with clinical mental health/behavioral health issues.[53] Those findings comport with OCA's review of records for this sample of youth, which finds that 63 percent of youth have a mental health diagnosis recorded in their DYFS file.

The Chapin Hall Center for Children at the University of Chicago recently published recommendations calling for an increase in the provision of evidence-based medical and mental health treatment for foster youth and alumni. Similarly, the American Academy of Child and Adolescent Psychiatry (AACAP) reports that "over 500,000 children reside in foster care in the United States, and 85 percent of them are estimated to have an emotional disorder and/or substance use problem."[54] The Child Welfare League of America and AACAP began an initiative in March 2001 to improve the design, delivery, and outcomes of the mental health and substance abuse services provided to children in foster care and their families, publishing the following policy statement:

> We must develop innovative and evidence-based assessment tools to identify children's emotional and/or behavioral problems as early as possible and to ensure that all children and their families

[52] *Id.at* 33.
[53] Office of the Child Advocate, *Needs and Assets Assessment of the Comprehensive Health Evaluation for Children (CHEC) Program* 3 (2005). That assessment found that 15.8 percent of children six and over had been diagnosed with post-traumatic stress disorder, 21.1 percent had been diagnosed with depression, and 100 percent had been diagnosed with general behavioral health issues. *Id.* That assessment also found that those children had rates of follow up care of 66.7 percent, 37.5 percent, and 29.2 percent respectively. *Id.*.
[54] American Academy of Child and Adolescent Psychiatry and The Child Welfare League of America, *AACAP/CWLA Foster Care Mental Health Values Subcommittee – Policy Statement* (2001).

> have access to and receive evidence-based, effective mental health and substance use prevention/treatment services, and supports. We believe it is our professional responsibility to provide the timeliest, most appropriate and effective prevention/treatment services and supports to children and their families to ensure the best outcomes. Key strategies for accomplishing these goals are:
>
> - Keeping children and their families involved whenever possible;
> - Providing the children with services and supports in their own community;
> - Responding to their needs with staff who understand their culture and programs that are culturally relevant to children and their families; and
> - Treating their mental health and substance use needs in a timely manner with professionals trained in the most effective prevention/treatment approaches.[55]

B. Life Skills Instruction

National best practice in life skills provision dictates that skill instruction should be comprehensive, begin early, and continue as an integral and evolving part of every child's experience while in foster care.[56] The underlying theory is that youth in care are entitled to – and need – the same learning experiences and opportunities to develop decision-making, problem solving, and general daily living capabilities as their non-foster peers. In traditional family settings, life skills instruction occurs most commonly in an informal manner as a normal component of parenting and raising children. Outside of the birth or relative care rubric, learning opportunities still exist, but frequency and continuity are less assured. Accordingly, life skills instruction is heralded as a necessary supplement to maximize healthy development.

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[55] *Id.*

[56] Independent Living Advisory Committee, Wisconsin Department of Health and Family Services, Division of Children and Family Services, *Independent Living for Children in Out-of-Home Care* (hereinafter "*Independent Living*") 16. That report also notes that, with regard to life skills development, the development of these skills should not begin in adolescence and should be taught throughout childhood. *Id.* at 17.

Successful life skills programs instill knowledge and understanding of a core set of skills and opportunities to practice those skills in a "real world" environment.[57] Most life skills programs teach youth employment skills, money management, communication skills, decision-making skills, skills to locate housing and community resources, housing maintenance skills, social skills, and skills promoting the formation and maintenance of healthy relationships. Less commonly included, but nonetheless important areas of skill development include vocational training, computer skills, and driver's education.

Resource parents have been identified as critically important participants in and facilitators of independent living instruction. In order to best utilize resource parents for the teaching of life skills, public child welfare agencies should establish the mandatory inclusion of accurate information on how to access life skills training for youth, and an overview of the curriculum. Resource parents also need to know how to engage in a system that calls for multi-agency transitional planning.[58]

A report by the Wisconsin Department of Health and Human Services made recommendations for individual living preparation services/life skills training, including basing life skills training on each individual child's assets, needs and maturity, involving youth in the service planning process, utilizing a strength-based approach, and involving the community and others in preparing youth, and recognizing and addressing any special needs of children.[59]

The following best practices are recommended by the Annie E. Casey Foundation in order to help youth obtain and gain proficiency in tangible (money management, credit,

[57] National Child Welfare Resource Center for Organizational Improvement, *Promising Practices: Supporting Transition of Youth Served by the Foster Care System*, 20-21.
[58] *Independent Living*, 17-18.
[59] *Id*. at 19.

consumer skills, education and employment) and intangible life skills (decision-making, problem-solving and social skills):

1. Begin life skills instruction early and extend life skills training beyond age 18;

2. Assess youth's level of self-determination and sense of hope for the future and help youth develop hope, motivation, self-determination;

3. Help youth develop characteristics that are necessary to develop self-determination (assertiveness, creativity, pride and self-advocacy);

4. Educate youth in transition on responsible parenting skills so that they are able to attach to their children, do not defer their own needs, and do not feel that they will become bad parents;

5. Ensure that youth, staff and caregivers understand that acquiring life skills is a life-long proposition;

6. Provide opportunities for youth to practice life skills in a "real world" environment;

7. Ensure that staff and caregivers are trained to teach a core set of life skills to youth;

8. Use the Ansell-Casey life skills assessment to track progress; and

9. Assess each youth's level of attachment to others and promote relationships with significant adults.[60]

DYFS has utilized the expertise of the United States Department of Health and Human Services Administration for Children and Families designated National Resource Center for Youth Services at the University of Oklahoma for many years in order to develop a life skills curriculum, known as the "Ansell-Casey Life Skills Tool." This curriculum and tool have also

[60] Casey Family Programs, *It's My Life: A Framework for Youth Transitioning from Foster Care to Successful* Adulthood, 34-38 (2001).

been adapted to conform to New Jersey's statutes, regulations and policy. However, the data in this audit suggests that, at least as of May 15, 2005, DYFS case practice did not conform to best practice or policy in this regard. This sample did not show that important assessment and skill building tools were routinely provided to, and accessed by, youth in resource family settings, nor was the curriculum universally applied as the program model/curriculum for youth in congregate settings.[61] DHS advises that it has made training on the Ansell-Casey Life Skills Tool and curriculum available to 15 offices and intends to continue the training expansion.

C. Intensive Case Management

To be effective in the current system, the DYFS case manager is expected to know the strengths and needs of each child on his or her caseload and facilitate the youth's connection to services and resources. At the same time, the case manager is expected to be vigilant with regard to the child's safety and ensure that the child is in a safe placement. To satisfy this charge, case managers must serve as more than service brokers. Moreover, it is imperative (as recognized by case practice and policy) that the DYFS case manager must keep a comprehensive file that documents every interaction with a child, whether with DYFS directly or with another public or private service provider. The case manager undoubtedly has ready access to the DYFS file, but may not have similar access to another agency's file. Plainly, ready access to comprehensive information about a youth is critical to informed case practice.

In addition to the central role played by the caseworker, multidisciplinary case planning is widely recognized as beneficial to youth in achieving holistic, effective service provision. The Administration for Children and Families in New York City has embraced such practice, making

[61] DHS has reported to OCA that DYFS has self-identified this problem and is currently training all congregate care providers in the State in the utilization of the Ansell-Casey Curriculum, and has pledged to a future modification to contracts to ensure mandatory benefits to all youth in congregate care.

professionals and other caring adults integral participants in recruiting foster parents and creating child and family centered case planning. With regard to transition planning, the Center for the Study of Social Policy is piloting a similar "family team" technique in one city to explore the same type of approach to transition planning for youth leaving the foster care system.[62]

Helping youth make the transition from placement to independence requires intentional and concerted efforts from youth and providers alike. National best practice and information obtained from the provider community in New Jersey identify and reinforce the following as the cornerstones of serving adolescents:

- Low case manager to youth ratios;
- Frequent and effective contact between youth and their case managers;[63]
- Creating – or recreating – community and family support for youth, so their journeys are supported;
- Identification of the individual strengths and needs of each youth (*i.e.*, the avoidance of "cookie cutter" or "assembly line" planning for youth);
- Linking youth to services to address their needs or deficits; and
- Youth participation and "buy-in" throughout the process.

The OCA encourages all efforts to incorporate these essential principles into routine and meaningful case practice for all adolescents in care.

[62] *See* The Center for Community Partnerships in Child Welfare of The Center for The Study of Social Policy, *Circle of Friends: Supporting Youth and Young Adults "Aging Out" of the Foster Care System* (2005) (draft) (on file with the OCA).

[63] Effective contact may include discussion of goals, assuring services are being delivered timely and appropriately, and gives the youth the opportunity to express concerns and opinions about the course of the case plan.

IV. PROMISING DEVELOPMENTS

A. Policy Changes

The recent decision by DYFS to lower the age at which life skills instruction is to begin for youth in out-of-home placement is an example of progressive policy reform.[64] The change reflects a clear recognition of the need to begin assessing a youth's strengths and needs and developing self-sufficiency skills early. Providing these skills at an earlier age to all youth in out-of-home placement for whom adoption or reunification is unlikely has the potential to enhance youth's ability to transition successfully to independence.

Another important policy change, made possible through legislation enacted several years ago, is that youth aging-out of foster care, most of them without family supports, are eligible to have their tuition costs at New Jersey's public universities and colleges paid by the State. DHS reports that 400 youth are currently enrolled in this important program, which provides a strong bridge to independence through education.

B. The LGBTQI Work Group

Although the OCA's case file review revealed only one instance of a youth that had affirmatively self-identified as a sexual minority, there is ample national data to support that significant percentages of foster youth are confronting questions of sexual identity issues and/or are gay, lesbian, bisexual, transgender, questioning, or inter-sex.[65] DYFS has taken an important

[64] *A New Beginning*, 97.

[65] It should be noted that to be fully inclusive the acronym LGBTQI should be amended to include an "I" at the end to represent youth that are inter-sex, hence becoming LGBTQI. An inter-sex youth is a child that was born with genitalia that is not clearly male or female, secondary sexual characteristics of indeterminate sex or which combine features of both sexes. *See, e.g.*, State of Connecticut, Department of Children and Families, II Policy Manual 30-9, *at* http://www.state.ct.us/dcf/Policy/IntroVol2_30/30-9.htm (visited January 3, 2006).

and proactive step to better understand the specific service needs of gay, lesbian, bisexual, transgender, questioning, and inter-sex (LGBTQI) teens by forming the LGBTQI work group, which consisted of representatives from multiple DHS offices as well as individuals from the New Jersey Gay and Lesbian Coalition, Legal Services of New Jersey. The work group has made the following recommendations for improved services to LGBTQI youth: (1) continued training efforts for staff and youth; (2) review of policy to ensure that it addresses the LGBTQI population; (3) development of a resource directory to assist LGBTQI youth and case managers to find services specific to the needs of this population; (4) recruitment of resource parents who will foster and adopt LGBTQI youth. These are sound recommendations that DHS should adopt and implement.

C. Expansion of Supportive Housing

As promised in New Jersey's child welfare reform plan, DHS has continued to expand the continuum of housing with supportive services for 16-21 year old youth who have not been reunified with family or adopted and will need to live independently. The continuum of supportive housing begins with "transitional living programs," which consist of "residential care and treatment services" and various supports.[66] For those youth, 18-21 years old, who are ready for further independence, the continuum may include congregate or scattered site apartment housing, with regular visitation by case managers, and the availability of ongoing services and 24-hour emergency supports. DHS has also indicated that it is working with the New Jersey Department of Community Affairs to explore permanent housing options for aging-out youth. The participation of DCA in this effort is critical, as that agency has the authority to distribute

[66] *N.J.S.A.* 9:12A-8.

state and federal rental and permanent housing assistance.[67] Moreover, in the last two years, DHS has increased the budget for aging-out youth by $6.7 million dollars to a total of $11.5 million. In April 2005, transitional living and supportive housing options were expanded by 43 beds with $1.7 million of these funds.[68] Recently, DHS awarded contracts to expand by 80 the number of transitional living placements for aging-out adolescents, including special populations of youth.

V. RECOMMENDATIONS

The data from this audit reveals gaps between some agency policies and practices with respect to 15-year-old youth in care as of May 15, 2005. These lapses invite aggressive remedial efforts to increase agency accountability and ensure that case planning for all adolescents in out-of-home placement includes: (1) needs assessments; (2) appropriate life skill instruction; and (3) meaningful transition planning. Absent greatly intensified and expedited efforts to improve case worker knowledge and skill in serving adolescents, many youth will continue to leave care unprepared for life on their own. Accordingly, the OCA calls for heightened accountability and rigor in case planning for all youth in out-of-home placement through the following recommendations.

A. Mental Health Assessment, Diagnosis and Treatment

1. Provide mental health assessment and, where appropriate, treatment and services for youth in out-of-home placement. Within 30 days of entering out-of-home placement all children are currently supposed to receive a

[67] *See* http://www.state.nj.us/dca/hmfa/biz/devel/specneed/programs.html#2 (visited January 3, 2006).
[68] Department of Human Services, *Human Services Announces $1.7 million housing expansion for aging out youth*, (April 12, 2005), *at* www.state.nj.us/humanservices/Press-2005/housing_expand.htm (visited January 3, 2006).

comprehensive health evaluation and linkage to care and services, including mental health care.

2. Promote equity and efficacy in the provision of mental health services to children in out-of-home placement by expanding the evidence-based models of intervention with children and families. This strategic effort should build on New Jersey's existing service providers, leverage New Jersey's evidence-based programs, and include New Jersey's academic institutions as partners in training, research and quality assurance. For example, DHS reports that it has awarded a contract to New Jersey CARES to replicate their nationally recognized model program in the treatment of child sexual abuse.

3. The apparently disparate access of African-American youth to mental health treatment in this sample warrants further investigation.

B. DYFS training

1. Require basic and continuing training for DYFS case managers on adolescent psychology, neuro-development and physical development. This training should prepare case mangers to prepare and meet the many challenges of working with adolescents and include instruction on how to effectively deal with oppositional youth.

2. The training curriculum on adolescent services and service provision for DYFS case managers and supervisors should be expeditiously implemented and made mandatory for all case managers and supervisors. All case managers should to be trained on the purpose and administration of the Competency Based Life Skills Program.

3. Partner with proven adolescent service providers in New Jersey to train DYFS case managers on case planning techniques that identify strengths and needs, engaging youth in a successful case management relationship, and positive youth development strategies.

4. In consultation with experts, develop and implement a mandatory training curriculum for all DYFS case managers and supervisors on LGBTQI issues. Require DYFS contracted residential and life skills programs to attend LGBTQI trainings as part of licensure.

5. DYFS should ensure comprehensive and mandatory training for all DYFS workers on the trauma associated with loss and separation. The importance of understanding the effects of abuse and neglect and the trauma of removal from the birth parents or relatives on the psyche of children and youth into adulthood is imperative for all DYFS case

managers and supervisors. It is crucial that the training emphasize that this is a continuous process and that every new placement or transition may trigger these feelings and cause additional trauma.

C. DYFS Case Practice

1. Consistent and meaningful MVRs and concurrent permanency planning are two elements of case practice that need heightened measures of supervisory oversight and management accountability.

2. Require that all case managers complete strengths and needs assessments with teens at least every 12 months, and prior to referral to life skills programs. All case mangers should be independently aware of the strengths and needs of the youth on their case loads to maximize service delivery and case planning.

3. Review the current distribution and allocation of federal Chafee funds under Title IV-E, in order to provide more equitable access to services for all youth, in both family and congregate placement settings. Ensure congregate care providers offer life skills programs to all youth age 14 and older in placement, and for youth in family settings, a designated community provider program.

4. Require that all case files contain photo copies of at least two forms of identification including birth certificates or Certificates of Naturalization and social security cards for U.S. Citizens and immigration documents and social security cards for non U.S. Citizens.

5. Formal transition planning conferences should begin with youth no later than age 15, in compliance with DYFS policy and the administrative code

6. A coordinated transition planning process for youth, engaging local, county and State programs, across a youth's life domains, should be piloted and evaluated.

7. In order to strengthen the role of resource parents in assuring youth have access to life skills training and informal training at home, the agency would do well to develop strategies for stabilizing youth in their placements, and provide greater likelihood that the development of meaningful relationships will occur.

Many of these recommendations comport with the commitments made by the State in its Child Welfare Reform Plan and, based on recent discussions with DHS, the OCA has a measure

of confidence that DHS is implementing the building blocks necessary to meet those commitments.

APPENDIX

Audit Methodology

A. Sample Selection

The sample of files subject to this review was randomly selected from a list of all 15-year-old youth in out-of-home placement as of May 15, 2005 (759).

B. Instrument validation

The audit tool was developed by the OCA. The instrument was provided to two external experts in research design and data collection techniques, both of whom have extensive experience and knowledge of the target population. The tool was then refined through three comment and critique sessions in which all readers reviewed the instrument in detail. Each review led to a modified iteration of the instrument that was amended according to group consensus.

C. Reader Training

The seven audit reviewers all have experience working with teens in out-of-home placement. The team was comprised of five licensed attorneys, four of whom have served homeless teens directly over many years, one Masters-level social worker and a graduate student with multiple years of work experience with at-risk adolescents. Prior to training, each reader reviewed a binder of materials, including current DYFS policy outlining case practice standards for adolescents in care, blank DYFS forms that would be involved in the review, recently

published literature on best practices, and the adolescent section of New Jersey's Child Welfare Reform Plan.

A full day training session was held for all readers on November 4, 2005. The training began with a question-by-question review of the assessment tool. The proper way to interpret each question was established to provide for normalization of response. Additionally, the training process clarified definition for all potential answers to every question. The tool also included prompts or reminders for the proper DYFS file documentation associated with each question.

A training file was removed from the sample and each reader was given a copy to read and code independently. Readers were instructed to read and review entire files and not to draw inferences from information available in files, but rather to complete the tool objectively, utilizing only the information plainly stated or contained in the file. Following each reader's completion of the practice training file, the coding sheets were discussed in a group exercise in which the answer to each question was reviewed to ensure that the reader had a clear understanding of each question and had answered the questions correctly based on the information presented in the file.

D. Quality Assurance

One of the two principal investigators was selected to maintain the controls necessary for quality assurance. Each reader's first file was re-read by this designated principal investigator. In addition to the initial re-reading of all seven first files, the instrument contained a reader assessment section that allowed for all readers to request a second read. All such requests were satisfied. Finally, a 10 percent random sample of completed files was also selected for re-

reading. In total, 14 files (20 percent) of all files received a second read by the designated principal investigator.

E. Data Analysis

Data collected through the instrument was entered into a database by research staff and analyzed using the Statistical Program for the Social Sciences (SPSS) software. Specific analysis techniques for quantitative data included frequencies, measures of central tendency and cross-tabulations. Staff analyzed qualitative data using standard content analysis procedures.